

LAB REPORT

001238

GRAM STAIN:	Few	Mod.	Many
Gram Positive Cocci in Clusters			
Gram Positive Cocci in Pairs and/or Chains			
Gram Positive Bacilli			
Gram Negative Diplococci			
Gram Negative Bacilli			
WBC's			

ORGANISMS SEEN: ☐ ANALYST:

CULTURE:

NO BETA-HEMOGLYDIN STREPTOCOCCUS DETECTED

ANALYST: DV

Collected By: J. DeSantis Time Collected: 1920

☐ Urine Culture { ☐ Cath ☐ Sensitivity ☐ Suprapubic
☒ Beta Strep Screen ☒ Throat ☐ N/A
☐ Blood Culture & Sensitivity
☐ Stool (Salmonella, Shigella, Campylobacter, Yersinia) T
☐ GC Screen ☐ Vag ☐ Cx ☐ Ureth ☐ Rect ☐ Throat

SEND SEPARATE SLIP FOR EACH SQUARE CHECKED

CHART

SBF Form 0688 1/84

BACTERIAL CULTURES
MICROBIOLOGY

1

COMMENTS: 118 SWOLLEN NECK 6:40P

Patient Acct. No. 52152170	Registration Date 08/06/1984	Time of Regis. 06:43PM	Chg. Ind.
Patient Type E	Hospital Service MED	Fin Cl S	
Patient Name MOORE LEE E		Birth Date 10/19/1974	
Sex/MS M/S	Ethnic B	AKA	
Patient Address 1280 MEREDITH DR		City CINTI	
State OH	Zip Code 45231	Home Phone 513-522-9203	
Mar. Stat. of Patient D DIVORCED	Guardian Name		Relation
Father's Name		Mother's Name MOORE GEORGIA L	
Medicare No.	Eff. Date	34061	Med. Rec. Number 4302600
Guarantor Name MOORE, GEORGIA		Rel. Cd.	Social Sec. No.
Home Phone 513-522-9203		Guarantor Address 1280 MEREDITH DR	
City CINTI	State OH	Zip Code 45231	Business Phone
Employer GM		Occupation FACTORY	
Employer Address SMITH RD		City CINTI	State OH
Blue Cross No.	BC Plan No.	Effective Date	Type
Subscriber		Relationship	
Company Name		Address	
City, State & Zip Code			
Policy No.		Commercial Ins. Name	
Group	Effective Date	Subscriber	Relation
Company Name		Address	
City, State, Zip Code			
Medicaid No.	ADD No.	Case Name	
Category	Grade	Country	Void Date
DCCS No.	State No.	State	
County	Effective Date	Expiration Date	
Blue Shield Plan	Effective Date	Other MD Code	Policy No.
Interviewer JLG	Ins. Code	Ins. Code	Ins. Plan

SBF Form No. 10M-100
 ASSIGNMENT OF BENEFITS: I authorize the release of all medical information related to the care and treatment of the above named patient requested by such agencies concerned with payment of charges of the authorized hospital service. I hereby authorize payment to the hospital and physician rendering services described herein. I understand that I am responsible to the hospital and physician for charges not covered by this authorization.

Signature: *Consent form* Relationship:

009055

0035 0793

MR 45025040 9 118
 MOORE LEE E
 521521770 M 10 19 74
 122 9207 0 6 84
 DR KEGLER

EMERGENCY DEPARTMENT REGISTRATION FORM

Children's Hospital Medical Center
 3300 and Bethesda Avenues • Cincinnati, Ohio 45229

Complaint or Cause of Accident

Place/Time/Date

SWOLLEN NECK

Patient Name

MOORE

LEE E

Arrival Time

0640P

Primary Source of Care

DR KEGLER

Who Sent You

SELF

Triage Person

LN

Triage To

MER

Temp

100.4

Pulse

100

Resp

32

B.P.

Weight

28.4

HISTORY/PHYSICAL

9yo Bm. 12 hrs of swollen @ node + sore throat. No URI
 Symptoms: Swelling @ side of neck - tender grad. & in sing
 throughout the day. St. hoarse speech. Low grade fever. No V/O
 No cough
 No PMHx → Dreshaw recurrent "raspy" voice not necessarily
 ass'd URI etc.

PE: Alert Bm in NAP Skin clean
 HENT - st. red post pharynx. 3 petechiae on uvula
 Tonsils clear. Eyes clear. Nose clear
 Neck - @ side 3x2 in firm st. tender post cerv. adenopathy
 Nonfluctuant & redness.
 Chest clear. CRR. HRS. Ab. benign. No HEN
 No other adenopathy noted

LAB RESULTS AND TREATMENT

- ☐ L. tes ☐ UA
☐ BUN ☐ UC
☐ BS ☐ BC
☐ Kidney Grp. ☐ T
☐ CBC ☐ SC
☐ ESR ☐ LP
☐ X-ray ☐ Other

Parents instructed to have his hoarseness rid
 one off med.

DISCHARGE INSTRUCTIONS / MEDICATIONS

Cefactor 250mg tid x 10d

- ☐ Fever ☐ Diet
☐ Antibiotics ☐ Casts
☐ Head Injury ☐ X-Rays
☐ Lacerations ☐ Hand
☐ Injuries ☐ Washing

PRIVATE / CLINIC DOCTOR CALLED

YES

NO

FOLLOWUP CARE DOCTOR

DATE

To Keble if not better 2d

DIAGNOSIS

CODE

Lymphadenitis

CONDITION UPON DISCHARGE

EXCELLENT

GOOD

FAIR

I HAVE BEEN INFORMED AND UNDERSTAND THESE INSTRUCTIONS

PHYSICIAN SIGNATURE

Dr. Heard

DISPOSITION

HOME

ADMIT

FOLLOW-UP

Positive

Culture

Positive

X-Ray

ATTENDING
 PHYSICIAN

Signature

SPECIALTY ☐ PEDI ☐ GEN. SURG ☐ OTHER

CONSENT I authorize the performance of any medical or surgical procedures deemed necessary for the diagnosis and/or treatment of the above named patient

SIGNATURE

RELATIONSHIP

Consent form

009056

0035 0792

COMMENTS: ENT SPEECH CL

Patient Acct. No.	Registration Date	Time of Regis.	Chg. Ind.
51021459	12/10/1992	02:50PM	
Patient Type	Hospital Service	Fin Cl	
E	ENT	X	
Patient Name	Birth Date		
MOORE LEE E	10/19/1974		
Sex/MS	Ethnic	AKA	
M/S	B		
Patient Address		City	
1290 MEREDITH DR		CINTI	
State	Zip Code	Home Phone	
OH	45231	513-522-1092	
Mar. Stat. of Parent	Guardian Name	Relation	
D DIVORCED			
Father's Name	Mother's Name		
	MOORE GEOGIA L		
Medicare No.	Eff. Date	Med. Rec. Number	
		34061 4302600	
Guardian Name	Rel. Cd		Social Sec. No.
FINNEYTOWN, SCHOOL DIST	0		
Home Phone	Guardian Address		
	8779 WINTON RD		
City	State	Zip Code	Business Phone
CINCINNATI	OH	45231	
Employer	Occupation		
Employer Address	City	State	Zip Code
Blue Cross Plan	BC Plan Cd.	Effective Date	Type
Subscriber	Relationship		
Company Name	Address		
City, State & Zip Code			
Policy No.	Commercial Ins. Name		
Group	Effective Date	Subscriber	Relation
Company Name	Address		
City, State, Zip Code			
Medicaid No.	ADC No.	Case Name	
Catech.	State	County	Void Date
BCCS No.	ADC No.	State	
County	Effective Date	Expiration Date	
Blue Shield Plan	Effective Date	Other MD Cover	Policy No.
Interviewer	Phy. Ins. Code	Ins. Code	Ins. No.
SD	X51	X51	

Form No. 0534-8-82

ASSIGNMENT OF BENEFITS: I authorize the release of all medical information related to the care and treatment of the above named patient requested by such agencies concerned with payment of charges of the authorized hospital service. I hereby authorize payment to the hospital and physician rendering services described herein. I understand that I am responsible to the hospital for charges not covered by this authorization.

Signature Relationship

009057

0035 0794

CHILDREN'S
Eland & BethesdaHOSPITAL MEDICAL CENTER
Cincinnati, Ohio 45229

EMERGENCY DEPARTMENT REGISTRATION FORM

12 10 82

ENT

430260*0
MCORE LEE E
31021459 M 10/19/74HISTORY PHYSICAL 12/10/82
XX51 ENT SPEECH

Complaint or Cause of Accident

Place/Time/Date

ENT SPEECH

Patient Name

Arrival Time

MOORE

LEE E

0200P

Primary Source of Care

Who Sent You

Triage Person

Triage To

FINNEYTOWN

DC

Temp.

Pulse

Resp

B.P.

Weight

TIME IN ROOM

TIME DISCHARGED

LAB RESULTS AND TREATMENT

- ☐ Lyles ☐ UA
☐ BUN ☐ UC
☐ BS ☐ BC
☐ Kidney Gro. ☐ TC
☐ CRC ☐ SC
☐ ESR ☐ LP
☐ X-ray ☒ Other

Stethoscope

DISCHARGE INSTRUCTIONS / MEDICATIONS

- ☐ Fever ☐ Diet
☐ Antibiotics ☐ Casts
☐ Head Injury ☐ X-Rays
☐ Lacerations ☐ Hand Washing
☐ Injuries

Condition Upon Discharge

☐ Excellent ☐ Good ☐ Fair

Date / Time

Follow Up Care Doctor

Date

Diagnosis

Code

VC Nodules

4785

Physician Signature

I HAVE BEEN INFORMED Parent Signature
AND UNDERSTAND
THESE INSTRUCTIONS.

DISPOSITION

- ☐ Home
☐ Admit
☐ Transfer

ADMITTING
PHYSICIAN

SPECIALTY

FLOOR

CONSENT: I authorize the performance of any medical or surgical procedures
deemed necessary for the diagnosis and/or treatment of this above named patient.

Signature

Relationship

FOLLOW-UP

- ☐ Patient contacted
☐ Physician contacted

☐ Positive _____ culture ☐ Positive _____ X-ray

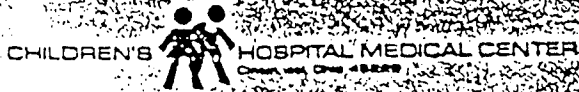
Comment:

Date

Signature

009058

0035 0790



12 10 82

ENT

CLINIC PROGRESS SHEET

51021459

430260-C

400RL LEE L

522 1092

CCCL

5

10/19/74

NAME

Q. D. 92 EW

Monrovia

Olympic

A

(R)

(L)

Oblique ✓

mus ✓

not on (R)

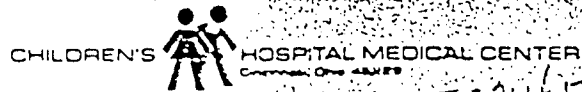
RA

009059

0035 0189

AMBULATORY REGISTRATION				CHILDREN'S HOSPITAL MEDICAL CENTER			
Patient Account No. 80594334	Registration Date 12/10/1982	Time of Registration 01:03PM	Ref. Type ENT	Med. Serv. ENT	Misc. Fee C	Fin. CL C	Pymt Sour. INT
PATIENT INFORMATION							
Patient Name MOORE, LEE E		Also Known As		Date of Birth 10/18/1974	Sex/MS M/S	Ethnic R	
Patient Address 1280 MEREDITH DR CINTI		State OH	Zip Code 45231	DR# 1000638COTTON, ROBIN MD.			
Mar. Stat. of Parents D DIVORCED	Father's Name		Mother's Name MOORE, GEORGIA L				
Patient Phone 513-522-1092	Guardian Name		Relationship	Previous CHMC Service			
Medicare No.	Effective Date	County Code 34061 HAMILTON, OH	Medical Record No. 4302600				
GUARANTY INFORMATION							
Name MOORE, GEORGIA L		Relationship MOTHER		Social Security No.		Home Phone 513-522-1092	
Address 1280 MEREDITH DR		City CINTI	State OH	Zip Code 45231			
Employer GENERAL MOTORS NORWOOD	Occupation RECAP CLERK		No. of Years 17Y	Business Phone 513-841-5093			
Address 4726 SMITH ROAD		City NORWOOD	State OH	Zip Code 45212			
INSURANCE INFORMATION							
Blue Cross No.	Relationship M MOTHER	Subscriber MOORE, GEORGIA L		Blue Cross Plan B11 BLUE CROSS SWO 332			
	Effective Date 05/01/82	Type 0370R	Company Name GENERAL MOTORS NORWOOD				
	Address 4726 SMITH ROAD		City, St., Zip CINTI OH				
Policy No.	Commercial Insurance Co. Name METROPOLITAN		Subscriber MOORE, GEORGIA L		Relationship M MOTHER		
	Group	Effective Date	Company Name GENERAL MOTORS NORWOOD				
Physician Coverage	Address To Mail Insurance Forms To 4726 SMITH ROAD		City, St., Zip CINTI OH				
Medicaid No.	ADC No.	Category	Case Name	State	County	Void Date	
BCCS No.	ADC No.	State	County	Effective Date	Expiration Date		
Blue Shield Plan	Effective Date	Other Physician Coverage			Policy No.		
Interviewer D.W.	Physician Ins. Code 002		Insurance Code B11	Insurance No.			
Complaint or Cause of Accident			Place	Date/Time			
Remarks NEW TO ENT CL							
Diagnosis							
Diagnosis Code		Surgical Code	CPT Code	Surgical Cutting Yes <input type="checkbox"/> No <input type="checkbox"/>			
Treatment & Lab Results:							
Follow Up Care Order							
Date			M.D.				
<p>"I hereby register my child for the _____ Clinic program at Children's Hospital Medical Center and authorize the performance of any medical treatment, diagnostic or routine procedures (which may require the use of sedatives or local anesthesia), and which may be reasonably expected to be a part of the normal clinic program."</p> <p>I understand that during the diagnostic or treatment activities of the Clinic, it may be in the best interests of my child to refer him/her to other Clinics within Children's Hospital Medical Center, to continue diagnosis, treatment or care of my child, I authorize such transfer to and treatment therein.</p>							
SIGNED <u>Georgia L. Moore</u>			RELATIONSHIP TO PATIENT		009060		

0035 0788



APPOINTMENT and ATTENDANCE RECORD

51021459

50

12-10-82
30260-C
HCCRL LEE E
10/19/74
22 1092
CC01

NAME

DATE OF BIRTH

REFERRED BY

APPOINTMENT DATE

12-10-82 ENT

WOODWARD HIGH SCHOOL

7001 READING ROAD
CINCINNATI, OHIO 45237

Office Phone 1-513-753-1200

Fax 1-513-753-1271

FAX TRANSMISSION COVER PAGE

DELIVER TO: Jessie H Love

FAX#: 614-644-0702 PHONES: _____

FROM: Dee Hanger, Registration

DATE: 12/2/99 TIME: _____

TOTAL NUMBER OF PAGES INCLUDING COVER PAGE: 7

(PLEASE CALL AT ONCE IF YOU ARE MISSING ANY PAGES)

COMMENTS: Lee E. Morn

This is all in information I have on
student

Dee,

The information contained in this facsimile message is Woodward High School's privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.

009062

MOORE, LEE E.

STU # 000750291
1280 MEREDITH DR
BORN 10/19/74

ID 000750291

MALE

RANK: (Based on Major subjects only)

COLLEGE RECOMMENDATION: Grades A through C

6 Semesters

In a class of

Cum. Ave.

8 Semesters

in a class of

Cum. Ave.

A = 90-100 (Excellent)
B = 80-89 (Above Avg.)
C = 70-79 (Average)
D = 60-69 (Below Avg.)
F = 0-59 (Failing)

Was or will

be graduated

W.D. 1-17-91

W.D. 6-1-91

W.D. 1/29/92

000750291 1989-90 MOORE, LEE E.

CUM-1.04761

PREVIOUS CREDITS-

PHYS ED I	C	D	C	.000
HEALTH	C	D	D	.250
ENGLISH I	C	D	D	.500
GENERAL MATH	D	D	D	1.000
C/P FRENCH I	C	F	F	1.000
ART I	F	D	D	1.000
ANIM KINGDOM	F	D	F	
TOTAL CREDITS-				3.750

Eng II Math, S.S., 91 D C C 1.000

Foods I - 1/2
Tge I - 1/2

credits earned 8-92

91-90 - 3 3/4

90-91 - 2 1/2

91-92 - 1 semester

6 3/4

Eng I, II - (III)
Math.

mail sent to Ann's on 1/29/92
sp. w. all teachers

MT. HEALTHY HIGH SCHOOL

2046 Adams Road

Cincinnati, Ohio 45231

Guidance Office

(513) 729-0181

OFFICIAL TRANSCRIPT

DATE 2-19-93

Dean Don

Registrar

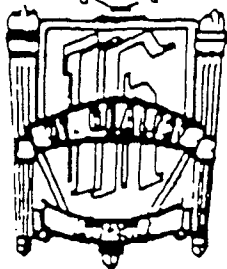
590600

Case 1:00-cv-00023-SJD-MRM

Document 120-84

Filed 08/08/2005

Page 13 of 20



MT. HEALTHY HIGH SCHOOL

2048 Adams Road, Cincinnati, Ohio 45231

Guidance Office
 (513) 729-0130

WITHDRAWAL PERMIT

PUPIL Lee Moore (750291) GRADE 10 DATE 1/29/93
 REASON moving out of district
 AUTHORIZATION _____

PERIOD	SUBJECT	GRADE TO DATE	BOOKS RETURNED			TEACHER SIGNATURE	AMOUNT OF FEE	
			YES	NO (BOOK NO.)	N/A		OWED	REFUND
1	Meteocology	N/A		✓ 36-78		<i>Feller</i>	-0-	-0-
2	English III							
3	Amer. History	N/A		✓ <i>Nietzsche</i>		<i>Walker</i>		
4	G. Alg. I Pt. 1							
5	P.E. II	N/A	✓			<i>Taylor</i>		
6	Careers	I		✓		<i>Kirby</i>		

LIBRARY J. Baker 1/29/93

ADMINISTRATIVE OFFICE John Strass

COUNSELOR R. [Signature]

ATTENDANCE OFFICE (Mrs. Wail) _____

FEES OR OBLIGATIONS (Mrs. Kallec) X

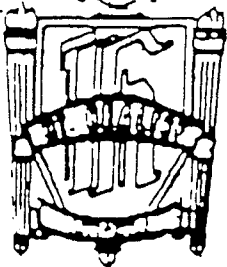
DATA PROCESSING (Mrs. McCann) Jander M. [Signature]

ATHLETIC OFFICE (Mrs. Stragand) _____

Lee E. Moore
 Parent or Guardian Signature

(TO RELEASE RECORDS)

009066



MT. HEALTHY HIGH SCHOOL

2048 Adams Road, Cincinnati, Ohio 45211

Guidance Office

(513) 729-0130

WITHDRAWAL PERMIT

PUPIL Lee Moore (750291) GRADE 10 DATE 1/29/93

REASON moving out of district

AUTHORIZATION _____

MODERN EARTH SCIENCE

PERIOD	SUBJECT	GRADE TO DATE	BOOKS RETURNED			TEACHER SIGNATURE	AMOUNT OF FEE	
			YES	NO (BOOK NO.)	N/A		OWED	REFUND
1	Meteorology	N/A		✓ 36-78		Foley	\$2.10	-0.00
2	English III	N/A		✓ 178-78 ^{McDonnell} _{Littel}		CW	\$2.00	
3	Amer. History	N/A		✓ ^{Ward}		Waller	\$1.80	
4	G. Alg. I Pt. 1	N/A		✓ 228-87		W.E.	\$6.00	
5	P.E. II	N/A	✓			Terry		
6	Careers	I		✓		Ray	\$4.50	

LIBRARY

P. Baker 1/29/93

ADMINISTRATIVE OFFICE

Belinda Stans

COUNSELOR

R. Stacy

ATTENDANCE OFFICE (Mrs. Weill)

Nancy Weill

FEES OR OBLIGATIONS (Mrs. Keller)

Jander McLean

DATA PROCESSING (Mrs. McCann)

ATHLETIC OFFICE (Mrs. Stragand)

Stragand

Eric E. Moore

Parent or Guardian Signature

(TO RELEASE RECORDS)

31
21
18
26
14.50
100.50

009067

1 mile, Lee C
first

IMMUNIZATION

TYPE	DATE MO/DAY/YR
DPT	11/24/74 12/28/74 4/28/75 7/26/76 1 1
OLIO	12/24/74 2/24/75 6/23/75 4/26/76 6/21/76 1 1
MEASLES	12/31/75 1 1 10-31-75 H-E UACC
UBELLA	12/31/75 1 1
UMPS	2/4/82 1 1
THER	1 1 1 1 1 1 1 1

equipped by comprehensive Immunization Inventory; 4 DPT; 3 Polio; 1 Live MMR Vaccine on or after child's first birthday; and 1 Rabies.

TUBERCULIN

DATE MO/DAY/YR	TYPE	RESULT	DATE MO/DAY/YR	TYPE	RESULT
1 1	True	POS	1 1		

POSTURAL SCREENING (SCOLIOSIS)

DATE MO/DAY/YR	RESULTS (Positive or Negative)	DATE REFERRED	ACTION TAKEN
1 1		1 1	
1 1		1 1	
1 1		1 1	
1 1		1 1	

DENTAL

TYPE OF PREVENTION PROGRAM			
FLUORIDE (Check)	TOOTH RINSE	NO. OF YEARS	INSTRUCTION (Type of Program)
1 1	1 1	1 1	1 1
1 1	1 1	1 1	1 1
1 1	1 1	1 1	1 1
1 1	1 1	1 1	1 1

ADDITIONAL SCREENING

DATE MO/DAY/YR	TEST	RESULT	DATE MO/DAY/YR	TEST	RESULT
1 1			1 1		
1 1			1 1		

HEARING

DATE MO/DAY/YR	AUDIOMETRY RESULTS (Pass/Fail)	OTHER TESTS (Specify)	DATE REFERRED	ACTION TAKEN
1 1	R L	R L	1 1	Med. Eval. Referral, T/A, Tubes, etc.
1 1			1 1	
1 1			1 1	
1 1			1 1	
1 1			1 1	

SPEECH and LANGUAGE

DATE MO/DA/YR		NORMAL	DISORDERS (Check)				DATE REFERRED	ACTION TAKEN (Check)		
			Artic.	Rhythm	Voice	Lang.		Speech Ther.	Med. Eval.	Other (Describe)
/	/						/	/		
/	/						/	/		
/	/						/	/		
/	/						/	/		
/	/						/	/		

VISION

DATE MO/DAY/YR	DISTANCE ACUITY	WEARS GLASSES	DATE REFERRED	ACTION TAKEN
1 1	R L		1 1	
1 1			1 1	
1 1			1 1	
1 1			1 1	
1 1			1 1	

SPECIAL NEEDS

DATE MO/DAY/YR	SPECIAL NEEDS OR CONDITIONS (See enclosed explanation)	TEACHER ALERTED
1 1		DATE 1 1
1 1		DATE 1 1



Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 644-9972

DAVID H. BODIKER
State Public Defender

Rec'd

1st Follow-up

2nd Follow-up

November 24, 1999

Central Baptist School
7645 Winton Rd.
Cincinnati, Ohio 45224

Attention: Records

Re: State of Ohio v. Lee E. Moore

Dear Sir/Madam:

Please be advised that the Ohio Public Defender is representing **Lee E. Moore** in the above referenced matter. The information requested herein is necessary for a detailed social history to be completed on his behalf.

In our efforts to properly represent **Mr. Moore** we are requesting that you provide us with any and all **education records** regarding **Mr. Moore**. These records should include, but are not limited to:

Education

- academic performance (grades), including
- teachers' names;
- attendance records;
- psychological and IQ testing dates and outcomes;
- disciplinary problems and/or other
- achievements/recognitions;
- attendance records;
- parent-teacher conferences;
- grade retentions and reasons;
- any organizational activities he may have been
- involved in;
- any other information pertinent to him, his
- siblings and his parents in relation to his
- academic performance.

009069

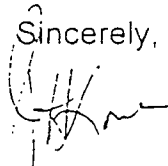
Central Baptist School
November 24, 1999
Page Two

To assist you in locating these records, Mr. Moore's birthdate is 10/19/74 and his social security number is [REDACTED]. His parents are Lee and Georgia Moore.

In addition to our records request stated above please indicate the name of your agency's custodian of records, as it may be necessary to have the authenticity of the documents verified. Please forward this information to Ohio Public Defender, Attn: Jessica H. Love on or before December 3, 1999.

An authorization for release of all such records is enclosed for your files.

Sincerely,



Jessica H. Love
Mitigation Specialist

JL/cw

Enclosure

#102093v1

009070



Office of the Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998
(614) 466-5394
FAX NUMBER: (614) 723-3670

AUTHORIZATION TO RELEASE INFORMATION

TO: Central Baptist SchoolRE: State of Ohio v. Lee E. Moore7645 Winton Rd.Cincinnati, OH 45224DATE: 11/24/99

You are hereby authorized to release to the Office of the Ohio Public Defender all records or other documents currently in your possession. Their representative may examine and make copies of all of my medical, psychological, hospital, police, and employment records, or any other records he/she may deem necessary in his/her work on my behalf. You are authorized to discuss these records and any other matters concerning me with said representative and are asked to assist him/her on the current investigation.

This authorization includes release of information concerning background, testing, and treatment of drug and alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV).

WITNESS:

Client's Signature

009071

Central Baptist Schools

Richard Voiles - Administrator

Michael Jones - Elementary Principal

7645 Winton Road • Cincinnati, Ohio 45224-1396 • Phone (513) 521-5481

November 30, 1999

Jessica H. Love
Ohio Public Defender
8 East Long Street
Columbus, Ohio 43215-2998

Dear Ms. Love,

Please find enclosed the information which you have requested. Our current Custodian of Records is Mrs. Sharon Jackson.

We are pleased that we could be of assistance.

Sincerely,



Richard Voiles
Administrator

009072